

Uterine Fibroid Baseline Study Abstraction of Surgical Medical Records - Surgery

STUDY ID: UFS	_____	_____	_____	TRACKING #: _____
FORM: <input type="text" value="2"/> <input type="text" value="2"/>	VER: <input type="text" value="0"/> <input type="text" value="1"/>	DATE OF BIRTH: <input type="text"/> / <input type="text"/> / <input type="text"/>		
		<small>MONTH</small>	<small>DAY</small>	<small>YEAR</small>

1. Records Available: *(Check all that apply.)*

<input type="checkbox"/> OPERATIVE	<input type="checkbox"/> PATHOLOGY	<input type="checkbox"/> OTHER, SPECIFY: _____ <input type="text"/>
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2. Date of Procedure: / / (1 FORM PER DATE)
(month) (day) (year)

3. Preoperative Clinical Diagnosis from Operative Report: *(Check all that apply.)*

<input type="checkbox"/> FIBROIDS	<input type="checkbox"/> MENORRHAGIA	<input type="checkbox"/> MENOMETRORRHAGIA
<input type="checkbox"/> DYSMENORRHEA	<input type="checkbox"/> PELVIC PAIN	<input type="checkbox"/> INFERTILITY
<input type="checkbox"/> UTERINE PROLAPSE	<input type="checkbox"/> URINARY FREQUENCY/ INCONTINENCE	<input type="checkbox"/> ADHESIONS
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> OTHER, SPECIFY: 1. _____	<input type="text"/>
<input type="checkbox"/> ENDOMETRIOSIS	2. _____	<input type="text"/>
<input type="checkbox"/> ADENOMYOSIS	3. _____	<input type="text"/>
<input type="checkbox"/> NOT MENTIONED	4. _____	<input type="text"/>

4. Findings:

- 4a. Adenomyosis? 1 YES 2 NO 3 NOT MENTIONED
- 4b. Fibroids? 1 YES 2 NO 3 NOT MENTIONED
- 4c. Adhesions? 1 YES 2 NO 3 NOT MENTIONED
- 4d. Ovarian cyst? 1 YES 2 NO 3 NOT MENTIONED
- 4e. Other 1 YES 2 NO 3 NOT MENTIONED

Specify:

1. _____

2. _____

3. _____

5. Uterine and Other Fibroid Related Procedures:

- 01 TOTAL ABDOMINAL HYSTERECTOMY 04 PARTIAL VAGINAL HYSTERECTOMY 07 OTHER, FIBROID RELATED
- 02 TOTAL VAGINAL HYSTERECTOMY 05 MYOMECTOMY
- 03 PARTIAL ABDOMINAL HYSTERECTOMY 06 UTERINE RESECTION
- SPECIFY: _____

6. Were tubes or ovaries removed?

- 1 YES 2 NO [SKIP TO 7]
- ↓

6a. What was performed? (Check all that apply.)

1 <input type="checkbox"/> BILATERAL SALPINGOOPHORECTOMY	1 <input type="checkbox"/> RIGHT CYST REMOVAL	1 <input type="checkbox"/> RIGHT OOPHORECTOMY
1 <input type="checkbox"/> RIGHT SALPINGECTOMY	1 <input type="checkbox"/> LEFT CYST REMOVAL	1 <input type="checkbox"/> LEFT OOPHORECTOMY
1 <input type="checkbox"/> LEFT SALPINGECTOMY	1 <input type="checkbox"/> OTHER SURGERY	1 <input type="checkbox"/> OTHER, SPECIFY: _____

7. Operative Sizing of Uterus: WEEKS

8. GnRH Analog Treatment Mentioned? 1 MENTIONED 2 NOT MENTIONED

9. Was uterus removed or measured?

YES

NO [SKIP TO 10]



9a. **Uterine Size 1:** Length . X Width . X AP . cm

Uterine Size 2: Length .

Total: Length .

(Check all organs being weighed.)

9b. **Total Weight 1:**

. gms → UTERUS CERVIX OVARIES

TUBES OTHER, SPECIFY:

Surgical Findings:

10. Focal Fibroids?

YES

NO [SKIP TO 12]

DK [SKIP TO 12]



10a. **Number noted by surgeon:**



Length of largest: . cm

10b. **Sizes noted by surgeon:** *(Check all that apply.)*

SMALL

LARGE

MEDIUM

NOT MENTIONED

10c. **Locations noted by surgeon:** *(Check all that apply.)*

SUBMUCOSAL

SUBSEROSAL

NOT MENTIONED

INTRAMURAL

PEDUNCULATED

(NOTE: Question No. 11 was deleted)

Pathology Findings (continued):

12. Endometrial Staging:

- 1 PROLIFERATIVE → 1 early 2 mid 3 late 4 not mentioned 5 other, specify: _____
- 2 SECRETORY → 1 early 2 mid 3 late 4 not mentioned 5 other, specify: _____
- 3 ATROPHIC
- 4 OTHER, SPECIFY: _____

- 5 NOT MENTIONED

13. Pathology Diagnosis of Other Uterine Pathology: (Check all that apply.)

- 1 ADENOMYOSIS → 1 mild 2 extensive 3 extent not mentioned
- 1 ENDOMETRIOSIS
- 1 CERVICITIS → 1 chronic 2 acute
- 1 NABOTHIAN CYST
- 1 OTHER UTERINE PATHOLOGY, SPECIFY: _____

- 1 PATHOLOGY DIAGNOSIS NOT MENTIONED

14. Other Pathology Diagnoses: (Check all that apply.)

- 1 SALPINGITIS
- 1 OVARIAN CYST
- 1 OTHER, SPECIFY: _____

- 1 NOT MENTIONED